STATE OF NEVADA
DEPARTMENT OF HEALTH AND HUMAN SERVICES
DIVISION OF PUBLIC AND BEHAVIORAL HEALTH
Bureau of Child, Family Community Wellness
Suicide Event Review Presentation Data Collection Tool

Death Event Number: Year. Sequence	2015.00	Effective Date:	
1. Individual's Name/Locations		Last Name:	
First Name:		Middle Initial/Name:	
Zip Code of Residence		Zip Code, Location of Incident (Death)	
City of Residence	#N/A	City of Death	#N/A
County of Residence	#N/A	County of Death	#N/A
2. Dates/Age	**Youth**	Age at Date Death:	0
Date of Birth:		Date of Death:	
Place of Birth (State)			
3. Gender:		**4. Sexual Orientation:**	
5. Relationship Status:			
6. Sibling Status: Sisters		**Brothers**	
7. Children Status: Girls		**Boys**	
8. Employment History		Occupation/Profession	
Currently Employed		Laid Off (date)	
Quit (date)		Retired (date)	
Fired (date)		Disabled (date)	
9. Military Status (Affiliation)		Branch Service	
# of Deployments and when		Related to Military Member or Veteran	
		Military Era	
# of Combat deployments and when		Military Era	
		Military Era	
Type of Discharge and When			
Job Title			
10. Community Connectedness			
Member of Clubs/Social Organizations		AA 12 Step	
Religious Affiliation		Other Support Groups	
11. Education Attending School		**Education Level**	
12. Race and Ethnicity	**Hispanic**		
13. Recent Medical Health Care Involvement		**Prescribed Medication Current and Past**	
Recent visit to Doctor			
Approximate Date of last Visit			
Diagnosis			
Approximate Last ER visit			
Type of Doctor (specialty)			

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14. Suicide Attempts or History of Thoughts of Suicide		Time Between Last Attempt/Death	
Previous Suicide Attempts		Legal 2K Actions (Date)	
Number of Attempts		Same Method and Means	
15. Communicating thoughts of Suicide		Healthcare Provider	
Suicide Note		Witnesses	
Social Media Entries		Other	
16. Division, Bureau or Institution Eligibility Last Service Received Date [check the primary bureau or institution in which the individual has been eligible for services]			
Community Based Care Services		**Children, Youth, Elder and Families**	
Behavioral Health (Yes Date Received)		Protective Services (Yes Date)	
Developmental (Yes Date Received)		Foster/Adult care (Yes Date)	
Drug & Alcohol (Yes Date Received)		Abuse or Neglect (Yes Date)	
Elderly & Adult (Yes Date Received)		**Adult and Juvenile Justice Services**	
Homeless & Housing (Yes Date Received)		Current Incarceration (location Date)	
Hospital (Yes Date Received)		Previous Incarceration (location Date)	
Mental Disability (Yes Date Received)		Probation (location Date)	
Physical Disability (Yes Date Received)		Parole (location Date)	
VA Benefits (Yes Date Received)		Facing Possible Charges (Describe)	
17. Current or Past Life Situations Which Could have Lead to the Suicide, Tox report?			
Alcohol Intoxication at Time of Death		Loss of Job (or threat)	
Under Drug Influence at Time of Death		Problems with Work	
Interpersonal (Domestic) Disputes		Problems with School	
Divorce (# of times)		Financial Issues	
Death of a Family Member		Gambling Problems	
Thoughts of Suicide or actions by Family		Family History of Substance Abuse	
Current Self Harm		Home Foreclosure (or pending)	
Homelessness		Thoughts of Suicide/actions by Friend/Peer	
History of Substance abuse		Self Harm in the Past	
18. Location & Method (action or technics to carry out the act) **and Means** (instrument or object used to carry out the act)			
LOCATION		**SUFFOCATION/STRANGULATION**	
Own Residence		**JUMPING**	
Traveled < 1 Mile		**OVERDOSE**	
Traveled > 1 Mile		**HANGING**	
Left Town, Miles		**DROWNING/SUBMERSION**	
HOMICIDE/SUICIDE		**POISONING**	
Multiple Homicides/Suicide		**CUTTING**	
Single Homicide/Suicide		**INTENTIONAL VEHICLE CRASH**	
OWNER OF THE INSTRUMENT		**FIREARM**	
OWNER (SELF)		**LEGAL INTERVENTION**	
		Other	

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20. Death Review Presenter			
First Name		Last Name	
Middle Initial:		Name of Agency	